



Orthodontics
Where smiles start.

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WhereSmilesStart.com

Personal Information

Patients Name _____ Age _____
 Address _____ City _____ Zip _____
 Home Phone _____ Cell _____
 Email _____
 Birthdate _____ Social Security # _____
 Employed By _____
 Business Phone _____ Occupation _____
 Business Address _____
 Spouses Name _____ Cell _____
 Who may we thank for referring you? _____

Insurance Information

Person(s) Financially Responsible _____ Phone _____
 Do you have dental insurance? _____ If Yes, Name of Insurance Company _____
 If Different From Above: Insured Social Security # _____ Insured Birthdate _____

Medical History

Dentist _____ Physician _____ Oral Surgeon _____

<input type="checkbox"/> YES <input type="checkbox"/> NO DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO ANEMIA	<input type="checkbox"/> YES <input type="checkbox"/> NO PROLONGED BLEEDING
<input type="checkbox"/> YES <input type="checkbox"/> NO PNEUMONIA	<input type="checkbox"/> YES <input type="checkbox"/> NO EPILEPSY	<input type="checkbox"/> YES <input type="checkbox"/> NO FAINTING/DIZZINESS
<input type="checkbox"/> YES <input type="checkbox"/> NO HEART TROUBLE	<input type="checkbox"/> YES <input type="checkbox"/> NO ASTHMA	<input type="checkbox"/> YES <input type="checkbox"/> NO NERVOUS DISORDERS
<input type="checkbox"/> YES <input type="checkbox"/> NO RHEUMATIC FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO KIDNEY INVOLVEMENT	<input type="checkbox"/> YES <input type="checkbox"/> NO LIVER INVOLVEMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO BONE DISORDERS	<input type="checkbox"/> YES <input type="checkbox"/> NO TUBERCULOSIS	<input type="checkbox"/> YES <input type="checkbox"/> NO ENDOCRINE PROBLEMS
<input type="checkbox"/> YES <input type="checkbox"/> NO HEPATITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO GLAUCOMA	<input type="checkbox"/> YES <input type="checkbox"/> NO HIV/AIDS

List any drugs or medications now being taken _____
 History of Allergies or Drug Sensitivity _____ Have you ever taken Fosamax or similar drugs? _____
 (FEMALES) Are you pregnant? _____ Are you presently taking birth control? _____

Dental History

Have there been any injuries to the face, mouth, or teeth? _____
 Are you aware of having a mouth breathing habit? _____
 Have you been informed of any missing or extra permanent teeth? _____
 Have you had an orthodontic consultation before? _____ Have you had orthodontic treatment before? _____
 If yes, when and where? _____

 Date of last dental examination _____
 What would you most like to have orthodontic treatment accomplish? _____

Signature _____ Date _____